MDR Tracking Number: M5-04-1771-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on February 17, 2004.

The Medical Review Division has reviewed the IRO decision and determined that **the requestor prevailed** on the issues of medical necessity. Therefore, upon receipt of this Order and in accordance with § 133.308(r)(9), the Commission hereby Orders the respondent and non-prevailing party to **refund the requestor $650.00** for the paid IRO fee. For the purposes of determining compliance with the Order, the Commission will add 20-days to the date the Order was deemed received as outlined on page one of this Order.

In accordance with §413.031(e), it is a defense for the carrier if the carrier timely complies with the IRO decision.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was not the only issue** to be resolved. The repair of orthotic device, supplies and materials, therapeutic exercises and activities, manual therapy, ultrasound, occupational therapy revaluation, and neuromuscular re-education rendered on 5/7/03 through 10/6/03 were found to be medically necessary. This dispute also contained services that were not addressed by the IRO and will be reviewed by the Medical Review Division.

On May 13, 2004, the Medical Review Division submitted a Notice to requestor to submit additional documentation necessary to support the charges and to challenge the reasons the respondent had denied reimbursement within 14-days of the requestor's receipt of the Notice.

The following table identifies the disputed services and Medical Review Division's rationale:

DOS	CPT CODE	Billed	Paid	EOB Denial Code	MAR$	Rationale
4/4/03	L8239	$30.00	$0.00	V	DOP	Review of the requestors and respondents documentation revealed that neither party submitted copies of EOBs, however, review of the recon HCFA reflected proof of submission. Therefore, the disputed services will be reviewed according to the 1996 Medical Fee Guideline. The requestor submitted relevant information to support delivery of service. Reimbursement is recommended in the amount of $180.00.
4/9/03	L4210	$150.00	$0.00	V	DOP	
TOTAL		$180.00	$0.00			

This Findings and Decision is hereby issued this 29th day of October 2004.

Margaret Q. Ojeda
Medical Dispute Resolution Officer
Medical Review Division

MQO/mqo

ORDER

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service 5/7/03 through 10/6/03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 29th day of October 2004.

Hilda Baker, Manager
Medical Dispute Resolution
Medical Review Division

HB/mqo

May 11, 2004

Rosalinda Lopez
Texas Workers' Compensation Commission
Medical Dispute Resolution
Fax: (512) 804-4868

CORRECTED REPORT
Corrected dates of service

Re: Medical Dispute Resolution
MDR #: M5-04-1771-01
IRO Certificate No.: IRO 5055

Dear Ms. Lopez:

___ has performed an independent review of the medical records of the above-named case to determine medical necessity. In performing this review, ___ reviewed relevant medical records, any documents provided by the parties referenced above, and any documentation and written information submitted in support of the dispute.

I am the Secretary and General Counsel of ___ and I certify that the reviewing healthcare professional in this case has certified to our organization that there are no known conflicts of interest that exist between him and any of the treating physicians or other health care providers or any of the physicians or other health care providers who reviewed this case for determination prior to referral to the Independent Review Organization.

Information and medical records pertinent to this medical dispute were requested from the Requestor and every named provider of care, as well as from the Respondent. The independent review was performed by a matched peer with the treating health care provider. This case was reviewed by a physician who is certified in Chiropractic Medicine who is currently on the TWCC Approved Doctor List.

REVIEWER'S REPORT

Information Provided for Review:
TWCC-60, Table of Disputed Services & EOB's.
Correspondence, letters of medical necessity & reports from occupational therapist, orthopedist, and physical medicine & rehab physician.
Publication and data regarding procedure and therapy.
Progress notes 02/03 through 10/03.
Physical and occupational therapy notes 03/03 through 12/04.
Operative report 04/03/03 and MRI 06/19/03.

Clinical History:
This claimant sustained a work-related injury on ___. At the time of injury, both hands were wrapped around several ropes. She sustained a fracture of the left proximal phalanx of the 5th digit on the left hand as well as the right hand 4th and 5th digits. The patient also had a sprain to bilateral wrists. Also in the records, it appears that she may have hyper-extended both shoulders and elbows. Her condition required surgical repair, and she has undergone intensive post-surgical rehabilitation.

The patient was initially seen by a doctor who immediately referred her to a surgeon for open reduction internal fixation of her injured fingers. This was performed on April 3, 2003. A post-surgical rehabilitation program was initiated. Over the course of treatment, an MRI of the right wrist was performed on 06/19/03, which revealed a tear or disruption on the ulnar side of the triangular fibrocartilage with posttraumatic synovitis, and in addition, ulnocarpal impaction syndrome.

Disputed Services:
Repair of orthotic device, supplies & materials, therapeutic exercises, therapeutic activities, manual therapy technique, ultrasound therapy, occupation therapy re-evaluation, and neuromuscular re-education during the period of 05/07/03 through 10/06/03.

Decision:
The reviewer disagrees with the determination of the insurance carrier and is of the opinion that the treatment, therapy and services in dispute as stated above were medically necessary in this case.

Rationale:
Over the course of treatment, there were several peer reviews, which indicated the patient's treatment plan was excessive. Under normal guidelines, it would have originally appeared that this patient's treatment was excessive; however, after careful review of all of the records it is clear that this patient suffered multiple injuries and has a unique case. At one point in the treatment plan, there was an attempt to return her to work on modified duty; however, the record indicated her employer refused to accept her back to work under these conditions. The records are clear, and there is specific documentation on each date of service and for each denied service to clearly and clinically justify this patient's ongoing treatment.

Sincerely,